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Internal Medicine Coding Alert

READER QUESTIONS: You Have to Carve Out G0101 and Q0091, Too

Question: Your article "How to Carve Out Your Reimbursement for Traditional Preventive Visits" in the June Issue of Internal Medicine Coding Alert did not mention carving out G0101 and Q0091 in addition to the same-day sick and preventive visit. Would you discuss that as well?

Mississippi Subscriber

Answer: When reporting to Medicare payers, you should carve out the charges for G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) the same way that you do for an E/M code (for instance, 99213, Office or other outpatient visit for the evaluation and management of an established patient).

Example: You want to report 99397 (Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations[s], laboratory/diagnostic procedures, established patient; 65 years and over), 99213, G0101 and Q0091 to Medicare. Therefore, this is how you should carve out the charges:

99397 = $130

99213 = 35

G0101 = 30

Q0091 = 25

Patient pays: $40

The reason: Medicare covers the pelvic/breast exam and the screening Pap smear as part of a preventive visit. You would be "double-dipping" if you charged the patient and Medicare for the exams and the preventive visit.

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